_	HEALTI	Н Շ)UE	ST	ION	INA	IRE	1																	
Î	Dear Patien	it: Pl	ease o	comple	ete this	aues	tionnaiı	re. Yo	oura	answers will he	elo u	s MO	tient Name DAY	YEA	R I	DR#			DA	TIEN	T NUI	MDEL			_
	determine if	we ca	an help	o you.	If we	do no	t sincer	rely be	liev	e your conditio	n wi		DAI	I LA		JR#			FA		INUI	VIDLN	Ì		-
	respond sati	sfacto	orily, we	e will n	otacce	ept yoi	ur case.	. THA	NK	YOU.		107		C			0		00		00	DO			
	Please use a	a No. 2	2 penc	il to fil	l in you	ur ansv	wers. V	Vhen f	illin	g in an Other bu	ubble			1000	D		1		DI			DŒ	D		D
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										<u>○Normal</u>	\bigcirc	Chills		h.	HEAR	T/L	UN	GS							
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										Itching	\circ	Other			⊖ Lu	•			. ,		$\bigcirc D$		-	•	
K	1. What are	-			-										$\bigcirc Re$		ess/	Itchi	ng		$\bigcirc 0$	ther			
S	<i>○</i> None	Pain Numbness Tingling						c.	NEUROLOGIC																
	Head	E E E							○ <u>Normal</u>	Fainting			i. STOMACH/INTESTINES												
Н	Neck		ND		D						\sim	Convulsi	ions	j.				NIE:	SIIN						
Е	Upper Back		D		D		D			 Dizziness 		Other			\bigcirc No		_				$\bigcirc V$		0		
R	Mid Back		MD		D		VD			EVEO	L										$\bigcirc D$				
E	Lower Back				-				а.	EYES		Disché	1 - 6								00		•	on	
	Shoulder	R	L	R	L	R	L			O Normal Vision Troub		Right			⊖ Ab	aon	11112	ai Pa	111		00	uner			
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	Leg									Hearing Trou	uble	\bigcirc	\bigcirc		⊖ Pa	0									
М	Foot	Ð	Ð	Ē	Ð	Ð	Ð			Ringing	-	$\overline{\mathbf{O}}$	0								ding				
A	L									Pain		\circ	\circ		-			0			5				
	2. Currently	/ you	r pair	ı is ag	ggrav	ated	by			Discharge		\circ	\circ	Ι.	GLAN	DU	LAF	२							
Κ	Coughin	-	-		⊃ Liftin		-			Other		\bigcirc	\bigcirc		<u> </u>	orma	al				⊖G	oiter			
S	○ Sneezing			\subset	Bend	ding									⊖ He			l Into	olerar	nce		remo	or		
			ool	\subset	⊃ Sittin	ng			f.	NOSE					⊖ Su	ıgar	In l	Jrine	Э		00	ther			_
Н	Neck Mo	oveme	nt	\sim	⊃ Stan	ding				◯ <u>Normal</u>															
E R E		g		\subset	⊃ Walk	king				○ Pain	\bigcirc	Absence	e Of Sme	ell m	. MENT	AL									
F	◯ Other										\bigcirc	Other			<u> </u>	orma	al					hobia	as		
															⊖ An	ixiet	y				OM	ood	Swir	ngs	
	3. Since yo		-		-	-			g.	MOUTH/THROA	T				⊂ De	pre	ssic	n			00	ther			_
	have you	ı noti	ced a	n char	nge ir	ו				◯ <u>Normal</u>	\bigcirc	Absence	e Of Taste	e	OMe	emo	ry L	.OSS							
	⊖ Bowel F	unctio	n	\subset	> Blad	der Fu	nction			⊖ Sores	\bigcirc	Abnorma	al Taste		or	ппр	airr	nent							
¥	○ Ability To	o Main	tain An	Erectio	on						\bigcirc	Other													
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2. What are your h	abits	?	casions	oderatel	V cessively	3. FAMILY HISTORY
	N	ever Or	Cast M	oderEx	cest	
Smoking	3	\$	\$	\$		
Alcohol	A	A	A	A		
Recreational Drugs	R	R	R	R		199
Exercise	Œ	Œ	Œ	Œ		Cancer Dianes Higher Sign Boouble
						Cancer Diabete St. Hiller
C.PAIN DIAGRAM						Father EEEE
Please mark the lo	catio	ו of y	our p	oain o	n these figures	Mother M M M
-	\		0	1		Brothers B B B B
	Sisters SSSS					
	3		أيويس			Children CCCCC
	61		YXY	-11		
-	All	h	Y	YI4		E.INSURANCE INF
- ////	171	- 17	'K _	411		
- // 4	117		$1\overline{Y}$			1. Is your condition
	143	200	14	1	·	accident
-	1		A.	d -		Date of Accident
- (Y)		- AV			Have You filed an
- \∦/	/		_\\#/	/		
			-78			2. Is your condition
						Date of Injury
				\frown	<	Have You filed an
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- (G. 4	11 =		6/5	3		3. Do you have healt
	-146		1/ /	1.1		Company

D.MEDICAL I	HISTORY
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1. HEALTH CARE No Yes a. Have you been to a chiropractor \odot b. Do you have a family physician \odot c. WOMEN: To the best of your knowledge are you pregnant Are you under the regular care of an OB-GYN ... \odot d. Have you been hospitalized in the past five years e. Are you currently taking any medication \odot O Anti-inflammatory (Aspirin, Motrin, etc.) ○ Muscle Relaxants O Pain Medication/Analgesic ○ Tranquilizers O Birth Control Pills ◯ Other

2. Which of the following illnesses have you had?

○ No Previous Conditions/Illnesses O Arthritis ⊖ Ulcer ◯ Asthma ⊖ Cancer ○ Sinus Trouble O Rheumatic Fever ⊖ Hay Fever ◯ Allergies ○ Serious Injury ○ Tuberculosis ○ Bone Fracture ○ Diabetes Dislocated Joints ⊖ Epilepsy O Spinal Disc Disease ○ Thyroid Trouble ○ Multiple Sclerosis ⊖ High Blood Pressure O Scoliosis ○ Low Blood Pressure O Mental/Emotional Difficulty O Heart Trouble O Prostate Trouble ⊖ HIV/ARC ○ Kidney Trouble ⊖ AIDS ◯ Other Sexually Transmitted Disease

	1
3. FAMILY HISTORY	N P C
Children CCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC	k
	8
E.INSURANCE INFORMATION 1. Is your condition due to an automobile accident	
Have You filed an accident report	>
2. Is your condition due to a job injury Date of Injury Have You filed an injury report	
3. Do you have health insurance ©	C
4. Are you covered by Medicare	F H av s y H F n F y H F n F
I WILL BE PAYING TODAY BY:	
○ Cash ○ Check ○ Credit Card	
○ MasterCard ○ Visa ○ American Express	
Account # Exp. Date All accounts not paid within 90 days will automatically be put through	
on your credit card. Patient's Signature Date	8
	1
Guardian or Spouse's Signature Date	E
	- F E
Doctor's Signature Date	
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